

Report of Voluntary Plan Claim

Please read instructions before completing this form

Part A Complete items 1 – 10 and submit within 15 days after receipt of a first claim for disability benefits.

1. SOCIAL SECURITY NUMBER - -	2. CLAIMANT'S NAME (FIRST, MI, AND LAST)	3. DATE DISABILITY BEGAN
4. CLAIMANT'S MAILING ADDRESS STREET/PO BOX		5. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY	STATE	ZIP CODE
6. DATE OF BIRTH		
7. PLAN NUMBER 99 -	8. EMPLOYER NAME	
9. DIAGNOSIS		
10. DO YOU WANT AWARD INFORMATION? <input type="checkbox"/> NO <input type="checkbox"/> YES (REMINDER: COMPLETE THE ADDRESS AREA AT THE BOTTOM OF THIS PAGE)		

FOR DEPARTMENT USE ONLY

EFFECTIVE DATE OF CLAIM / /	WEEKLY BENEFIT AMOUNT \$	MAXIMUM BENEFIT AMOUNT \$
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Part B Complete items 11 – 18 and submit within 35 days after final payment for each period of disability.

11. NUMBER OF DAYS BENEFITS PAID	12. BENEFITS PAID THROUGH	13. TOTAL AMOUNT OF BENEFITS PAID	14. TOTAL AMOUNT DIVERTED TO SATISFY SUPPORT OBLIGATION
15. CLAIM STATUS (CHECK ALL APPROPRIATE) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> BENEFITS NOT EXHAUSTED <input type="checkbox"/> BENEFITS DENIED (ATTACH DENIAL LETTER) <input type="checkbox"/> RECOVERED / RETURNED TO WORK <input type="checkbox"/> ADJUSTMENT			
16. TYPE OR PRINT NAME OF PERSON COMPLETING FORM		17. TELEPHONE NUMBER ()	18. DATE

SUBMIT COMPLETED FORM AS FOLLOWS:

INTERNET OR HARDCOPY VERSION: Print and mail to any State Disability Insurance office.
(Please do not attempt to e-mail the Internet version.)

DI SERVER VERSION: E-mail to either San Jose Disability Insurance office, vp2523sj@edd.ca.gov
or
North Los Angeles Disability Insurance, vp2523la@edd.ca.gov

IN THE AREA BELOW, ENTER THE NAME AND ADDRESS (INCLUDING ZIP CODE) OF EMPLOYER OR INSURER

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**INSTRUCTIONS FOR COMPLETING THE
REPORT OF VOLUNTARY PLAN CLAIM, DE 2523**

Part A (1 through 10) – To be completed and returned within 15 days after the receipt of a first claim for disability benefits (California Code of Regulations, title 22, section 3267-1).

1. Enter all digits of the claimant's social security number.
(A claim cannot be processed without an accurate number. The use of an incorrect number can result in erroneous notices to the claimant and employer.)
2. Enter the claimant's full name.
3. Enter the date the disability began.
4. Enter the claimant's current mailing address.
5. Enter a check mark in the appropriate box.
6. Enter the month, day, and year of claimant's date of birth.
7. Enter the voluntary plan number beginning with 99—_____.
8. Enter the employer's name.
9. Enter the physician's diagnosis.
10. Enter an "X" in the appropriate box. If yes is checked, the department will mail the award information to the address provided.

Part B (11 through 18) - To be completed and returned within 35 days after final payment for each period of disability.

11. Enter the number of days disability benefits were paid.
(Includes days paid under a supplemental accident and sickness plan or salary continuance only if they are part of the Voluntary Plan.)
12. Enter the last date for which disability benefits were paid by the voluntary plan.
13. Enter the amount of disability benefits paid from the voluntary plan.
(Enter the amount paid for the days entered in item 11. Include any amount withheld for support obligation.)
14. Enter the amount of disability benefits that were diverted to satisfy a support obligation.
(Enter the amount of benefits withheld and sent to the district attorney's office under the Support Intercept Program. This amount must be included in the total of item 13.)
15. Enter an "X" in the boxes that apply to the current claim status.
Benefits Exhausted: The total maximum award has been paid.
Benefits Not Exhausted: A balance of the maximum benefit amount remains.
Benefits Denied: No benefits have been paid. A copy of the denial letter to the claimant must be electronically attached or submitted under separate cover.
Recovered/Return to Work: The claimant has recovered from the disability and/or returned to work.
Adjustment: Use if submitting amended report.
16. Enter the printed name of the person completing the form.
17. Indicate the telephone number of the person completing the form.
18. Enter the current date.

In the space provided at the bottom of the page, type or print clearly the name and mailing address of the employer or the third party administrator.

SUBMIT COMPLETED FORM AS FOLLOWS:

INTERNET or HARDCOPY VERSION: PRINT and MAIL TO:	DI SERVER VERSION: E-MAIL TO EITHER:
Any State Disability Insurance office (Please do not attempt to e-mail the Internet version)	San Jose Disability Insurance office: vp2523sj@edd.ca.gov or N. Los Angeles Disability Insurance office: vp2523la@edd.ca.gov (You may also print and mail your report to any SDI office if you wish)